THE MARYLAND HEALTHY KIDS/EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM
PROVIDER APPLICATION FOR CERTIFICATION & PARTICIPATION

Provider Name:_____ **Group Name:**_____

Primary Address:_____ **Group #:** _____

City:_____ **State:**_____ **Zip:**_____ **County:** _____

Specialty:_____ **Ages Served:**_____ **Contact Person:**_____

Telephone:____-_____ **Fax:**____-_____ **E-mail** _____

MCO Participation (specify each MCO):_____/_____/_____/_____

I. *PROVIDER QUALIFICATIONS* (Check all that apply):

( ) National Provider Identifier (NPI) _____
( ) Currently participate in the Maryland Medical Assistance Program; provider number _____
( ) Currently participate with one or more Medicaid MCOs; MCO number (if not MA #) _____
( ) License number(s):_____ Specify state(s) _____

Provider shall meet one of the following requirements: (specify)

( ) Be board-certified, (circle specialty) pediatrics, family practice, internal medicine;
( ) Be a licensed physician or osteopath, or certified nurse practitioner, delivering primary health care to children and adolescents;
( ) Be a local health department or free standing clinic.

II. CONDITIONS FOR PARTICIPATION

All providers rendering preventive screening services to children must meet the following conditions, which are specified in the Maryland Healthy Kids/EPSDT Program regulations (COMAR 10.09.23) and Program policies:

(1) Provide or ensure the provision of the full set of screening procedures as outlined in the Healthy kids Schedule of Preventive Health Care and in a manner prescribe by the Department in the Healthy Kids Provider Manual;

(2) Provide inter-periodic and full screening as deemed medically necessary;

(3) Provide or arrange for: a) referrals for diagnosis, treatment, and follow-up services if the screening indicates a need for additional services; b) acute and tertiary care; c) long-term and rehabilitative care; and d) referrals for specialty mental health care when appropriate.

(4) Inform the parent or guardian of the need for preventive health care visits at the time of enrollment or assignment, and schedule appointments to facilitate adherence to the periodicity schedule (Schedule of Preventive Health Care).

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(5) Agree to cooperate with state and local health department efforts to assure that children receive needed follow-up and treatment services. This requires referrals to the local health departments when appropriate to track children for missed appointments and delays with immunizations and treatments.

(6) Maintain a patient record system that is sufficiently detailed and current to allow another physician who is unfamiliar with the patient to properly continue treatment in the absence of the primary care physician. Additionally, the record must sufficiently document the preventive screening components in accordance with the Healthy Kids Schedule of Preventive Health Care;

(7) Agree to on-site visits by the State program staff that will:

- Verify provider qualifications,
- Assess the need for provider/staff training, technical assistance, or in-service training,
- Review/audit Medical Assistance recipient charts to determine if the program standards are being met, if quality and quantity of child health services delivered is sufficient, and if appropriate referral and treatment services are adequately provided;

(8) Agree to participate in the Vaccines for Children (VFC) Program to assure that needed vaccines are readily available to the Medicaid enrollee according to the currently recommended Immunization Schedule, and

(9) Agree to cooperate with Department efforts to provide timely access for all child health services including services for children with special needs and children in state supervised care.

PROVIDER AGREEMENT

I_____(print name) agree to comply with requirement listed in Section II Conditions for Participation and understand I may be granted a provisional certification upon review of my application. I also understand that I may receive full certification status only after the completion of an on-site review.

Signature:_____Date:_____

DEPARTMENT CERTIFICATION

This provider meets the provider qualification requirements and conditions for participation listed in Sections I and II.

Full Certification granted on (date)_____

EPSDT Program Nurse Consultant Signature:_____

Return Address: **DHMH – Unit 79**
Division of Children's Services (EPSDT)
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Baltimore, MD 21201
FAX: 410-333-5426